



**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**

**Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch**

Ottawa Service Area Office  
347 Preston St, 4th Floor  
OTTAWA, ON, K1S-3J4  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ième</sup> étage  
OTTAWA, ON, K1S-3J4  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670

**Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité**

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Aug 13, 2013	2013_128138_0028	O-000320-13	Critical Incident System

**Licensee/Titulaire de permis**

REVERA LONG TERM CARE INC.  
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

**Long-Term Care Home/Foyer de soins de longue durée**

HEARTWOOD  
201-11TH STREET EAST, CORNWALL, ON, K6H-2Y6

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

PAULA MACDONALD (138)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): July 25, 2013**

**During the course of the inspection, the inspector(s) spoke with the Director of Care, a resident, and a personal support worker.**

**During the course of the inspection, the inspector(s) reviewed a resident health care record, reviewed Critical Incident (CI) Report, and observed a resident care area.**

**The following Inspection Protocols were used during this inspection:**



Personal Support Services

Findings of Non-Compliance were found during this inspection.

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**



---

**Specifically failed to comply with the following:**

- s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
  - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
  - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**
- 

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.6 (1) (b) in that the licensee failed to ensure that there was a written plan of care for a resident that set out the goals of care with respect to the resident's safe mobilization.

LTCH Inspector #138 reviewed a Critical Incident (CI) Report which indicated Resident #1 was sent out to hospital on a specified date and diagnosed with a fractured arm. The CI Report stated that the cause of the fracture was unknown but did indicate that the resident has issues related to safe mobility in the home.

LTCH Inspector spoke with the Director of Care who stated that the cause of Resident #1's fractured arm remained unknown and also stated that there was nothing unusual about the care the resident had received. The Director of Care did state that a possible contributing factor to the resident's injury may have been the resident's self mobilization on the unit as the resident is known to self propel his/her wheelchair into crowded, busy areas sometimes causing injury to him/herself.

The resident's health care record was reviewed including the progress notes. The progress notes reviewed indicated several incidents of injury to the resident's hand and/or arm related to self mobilization in his/her wheelchair. One specific progress note stated that the resident had poor insight to move safely and injures him/herself while in his/her wheelchair.

The resident's current plan of care was reviewed and it was noted that there were no written goals related to the resident's self mobilization in his/her wheelchair and the injuries s/he sustains while self mobilizing. [s. 6. (1) (b)]



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

---

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for Resident #1 sets out goals with respect to safe mobilization, to be implemented voluntarily.***

---

**Issued on this 13th day of August, 2013**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

*Paula Macdonald RD*